LIEW SIN KIONG

v.

DR. SHARON D.M. PAULRAJ

HIGH COURT SABAH & SARAWAK, KOTA KINABALU
TUAN IAN H.C. CHIN J
[SUIT NO. K182 OF 1992]
13 JANUARY 1996

TORT: *Negligence - Duty of care - Ophthalmologists - Whether necessary to consult patient's previous doctor - Whether necessary to explain risks of surgery to patient - Whether patient would have consented to surgery if risks explained - Whether doctor guilty of such failure as no doctor of ordinary skill would be guilty of - Whether course of action accepted by general body of practitioners - Whether negligent in referring patient to hospital without treatment.*

TORT: *Negligence - Res ipsa loquitur - Whether doctrine applicable - Eye surgery - Post-operative infection - Whether ophthalmologist negligent - Whether proper pre-operative prophylactic measures taken - Whether prima facie case of negligence rebutted.*

This was an action by the plaintiff against the defendant, an ophthalmologist, for damages for negligence pertaining to the operation (*trabeculectomy*) that was performed by the defendant on his right eye which was subsequently lost to post-operative infection. The plaintiff alleged that the defendant had failed to: (i) take all possible care and prophylactic measures to ensure that no post-operative infection occurred; (ii) take due or adequate care, and to ensure an aseptic technique or condition prior to, during, and after the surgery; (iii) procure the details of the plaintiff's medical history from the plaintiff's previous ophthalmologist; (iv) treat the plaintiff's right eye urgently after *panophthalmitis* had set in, and to provide adequate pain relief to alleviate the plaintiff's pain and suffering; (v) explain the possible complications and risks associated with the operation; and (vi) exercise the reasonable care and skill that could be expected of an experienced, skilled, and competent medical practitioner and/or consultant ophthalmologist. The plaintiff also alleged that his blindness was a direct result of the post-operative infection and not of *glaucoma*. Additionally, the plaintiff also relied on *res ipsa loquitur*.

Held:

[1] On the evidence it was apparent that the defendant had administered both oral and topical medication to the plaintiff prior to the operation. It was, therefore, not true that she had operated on the plaintiff's right eye without first stabilising the intraocular pressure of the eye.

[2] On whether it was necessary for the defendant to consult the plaintiff's previous ophthalmologist, the Court found that it was only necessary if the defendant thought so. The Court agreed that a good account of a patient's medical history could be obtained from the patient's own narration, and by examination and investigation. In the instant case, the defendant was aware that a *trabeculectomy* had previously been performed on the plaintiff, and thus, there was no need for her to consult the plaintiff's previous ophthalmologist. Consequently, there was no basis for alleging that the defendant's decision to perform the *trabeculectomy* was an unsound clinical judgment because she did not know that the plaintiff had previously undergone a *trabeculectomy*.

[3] There is, in law, a duty on doctors to warn their patients of any material risk in undergoing or foregoing surgery or treatment. In the instant case, the defendant must explain, and she did explain, the risks of post-operative infection to the plaintiff.

[4] In order to succeed in an action to recover damages for failure to give warning, a plaintiff must show, not only that the failure was negligent, but that if he had been warned he would not have consented to the treatment. In the present case, the plaintiff did not even indicate that had he been warned about the risks of post-operative infection he would not have consented to the operation.

[5] The true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proven to be guilty of such failure as no doctor of ordinary skill would be guilty of if acting with ordinary care. In the instant case, the plaintiff had failed to show that the defendant's decision to perform the *trabeculectomy* was not in accord with what is regarded as proper by a body of skilled ophthalmologists.

[6] The defendant did administer topical antibiotics to the plaintiff pre-and post-operatively, although none were given orally or intramuscularly. On the other hand, the defendant had failed to show that it was an established practice that pre-operative antibiotics must be administered orally or intramuscularly, and that a deviation from such a practice would amount to a breach of the duty of care.

[7] Medical science has still not reached the stage where the law ought to presume that a patient must come out of an operation as well or better than he went into it. Infections do occur despite proper pre-operative prophylaxis; therefore, it could not be said that the infection to the plaintiff's eye must have been due to the plaintiff's negligence. The infection could be one of those unexplained incidents of infection despite proper pre-operative prophylaxis. Consequently, the doctrine of *res ipsa loquitur* could not apply in the instant case.

[8] Even if *res ipsa loquitur* did apply, the defendant had rebutted the *prima facie* case of negligence by showing that she employed the accepted pre-operative prophylactic measures.

[9] The defendant was not negligent in referring the plaintiff to the hospital without treating his post-operative infection first. There was no evidence to show that what she did was not in accord with the practice accepted by the general body of practitioners.

[10] The defendant was not negligent in not administering pain-killers to the plaintiff intramuscularly before referring him to the hospital. A doctor is only required to prescribe pain-killers when a patient complains of pain, and there is no duty on the part of a doctor to enquire whether a patient is in pain when the patient does not complain of any pain.

Obiter dictum:

[1] It would be sad if doctors, just for the purpose of preventing themselves form being sued, would thrust to a patient every possible risk, however remote, that is associated with a surgery, with the result that the patient would rather not undergo the operation. If a doctor feels that a patient needs an operation the benefit of which outweighs a remote risk, and in the doctor's opinion, based on his assessment of the patient's traits, the patient may be deterred if that remote risk is told to him, then the doctor should be allowed the therapeutic privilege of deciding whether or not to tell the patient that risk.

[Claim dismissed with costs]

Cases referred to:

Sidaway v. Bethlem Royal Hospital Governers & Ors. [1985] 1 All ER 643 ***(cit)***
Christopher Rogers v. Maree Lynette Whitaker [1993] 1 CLJ 449 ***(refd)***
F v. R [1983] 33 SASR 189 ***(refd)***
Reibl v. Hughes [1980] 114 DLR (3d) 13 ***(refd)***
Bolam v. Friern Hospital Management Committee [1957] 2 All ER 118 ***(foll)***
Chin Keow v. Government of Malaysia & Anor. [1967] 1 WLR 813 ***(cit)***
Elizabeth Choo v. Government of Malaysia & Anor. [1970] 2 MLJ 171 ***(cit)***
Maynard v. West Midland Regional Health Authority [1984] 1 WLR 634 ***(cit)***
Kow Nan Seng v. Nagamah & Ors. [1982] 1 MLJ 128 ***(cit)***
MA Clyde v. Wong Ah Mei & Anor. [1970] 2 MLJ 183 ***(refd)***
Scott v. London & St Katherine Docks [1865] 3 H&C 596 ***(refd)***
Roe v. Minister of Health [1954] 2 QB 66 ***(refd)***
Lloyde v. Midlands Gas Board [1971] 2 All ER 1240 ***(refd)***
National Chemsearch Corp (SEA) Pte Ltd. & Anor. v. Hotel Ambassador (M) Sdn. Bhd. [1975] 2 MLJ 193 ***(refd)***
Wong Choon Mei & Anor. v. Dr Kuldeep Singh & Anor. [1985] 2 MLJ 373 ***(foll)***
Girard v. Royal Columbian Hospital et al [1976] 66 DLR (3d) 676 ***(foll)***
Considine et al v. Camp Hill Hospital et al [1982] 133 DLR (3d) 137 ***(foll)***

Poh Sun Hong v. Lim Peng Chia [1979] 1 MLJ xxxviii ***(refd)***
Rahim bin Sian v. Mesdi bin Warian [1985] 1 MLJ 442 ***(refd)***

Legislation referred to:
Evidence Act 1950, s. 152

Other sources referred to:
Survey of Ophthalmologhy, Vol. 39, at p. 491
Clerk & Lindsell on Torts, 16 Edn., para. 10-135
Principles and Practice of Ophthalmology, Vol. 2, Albert & Jakobiec, p. 1162
Surgery of the Eye, edited by Waltman & Ors., p. 74

For the plaintiff - Sugumar Balakrishnan; M/s. Sugumar & Co.
For the defendant - P.S. Ranjan (Vicky Lai with him); M/s. Dr. Yee Tan & Norbert Chin

JUDGMENT

Ian H.C. Chin J:

Introduction

The writ herein was taken out on 1 September 1992, by Liew Sing Kiong ("the plaintiff') who sues Dr. Sharon D.M. Paulraj ("the defendant") for aggravated or punitive damages for negligence pertaining to the operation of his right eye which was lost to postoperative infection. The allegations of negligence against the defendant are pleaded in the following terms:

(a) Not taking all possible care and prophylactic measures to ensure that a sight threatening infection does not occur post operatively;

(b) the plaintiff contracted panophthalmitis during surgery by not taking due or adequate care and not ensuring an asceptic technique or condition prior to and/or during the surgery until the conclusion thereof.

(c) despite the complexities of the plaintiff's case, no attempt was made to contact the plaintiff's previous doctor, the said Dr. Molly Elizabeth Matthew for details of past operations and/or complications and/or case history despite being informed that the plaintiff's previous doctor was the said Dr. Molly Elizabeth Matthew;

(d) failing to treat the plaintiff urgently on 13 July 1992 for panophthalmitis after this complication has settled in, in order to save the plaintiff's sight and for failing to provide adequate pain relief to alleviate the plaintiff's pain and suffering despite being qualified to do so and shunting him to the Queen Elizabeth Hospital, Kota Kinabalu when the plaintiff was willing for the defendant to treat him at the Sabah Medical Centre, Kota Kinabalu.

(e) failing to explain the possible complications and risk of blindness associated with the operation so that the plaintiff could have made an informed consent;

(f) the plaintiff's loss of sight is a direct result of the infection and not due to the glaucoma. The plaintiff's other eye did not go blind;

(g) failing in all the circumstances to exercise reasonable care and skill to be expected of an experienced, skilled and competent medical practitioner and/or consultant ophthalmologist; and

(h) the plaintiff will further rely on the doctrine of *res ipsa loquitur*.

Further particulars of the allegations were delivered. The defendant denied the allegations. The following are the facts of this case.

Facts of Case

The plaintiff was, until 11 July 1972, a quarry supervisor. He was since 1989 a patient of a government ophthalmologist Dr. Molly Elizabeth Mathew ("Dr. Molly"), a doctor with 22 years of experience as at the date of the trial. Dr. Molly treated him for juvenile glaucoma and the treatment included two operations under general anaesthesia on his eyes in 1990. Glaucoma is an eye condition where, because the optic nerve was damaged by raised intraocular pressure resulting from a build-up of fluid content in the eye-ball, the eye has decreased vision and fields of vision. The normal acceptable intraocular pressure is 21 mm. of mercury. The operations of 1990 that Dr. Molly performed on him were two trabeculectomies, one for each eye. It was done for the purpose of creating a channel for the out flow of the intraocular fluid which would reduce the intraocular pressure. The operations went well and the plaintiff retained his previous vision and the intraocular pressure was initially controlled with medication. However, as time progressed and despite maximum medication, the intraocular pressure could not be controlled and it was 34 mm of mercury on 9 July 1992, and it was on that day that Dr. Molly recommended the plaintiff to go to Kuala Lumpur for a Seton operation, which involved the insertion of a valve in the eye to control the pressure, which Sabah does not have the facility nor the doctor for such an operation and the only doctor who could do the operation was a Dr. Shukri who was in Kuala Lumpur. Dr. Molly was of the opinion that a re-trabeculectomy following a successful one would not help and that was the reason she thought a Seton procedure was necessary but this is not relevant because it is not the plaintiff's case that a Seton rather than a second trabeculectomy should have been done. Dr. Molly was hopeful that the plaintiff would agree to go to Kuala Lumpur and the plaintiff was asked to come back to see her. The plaintiff did not agree to go and he, instead, on the same day, that is 9 July 1992, went to see the defendant, an ophthalmologist, who was and still is in private practice. The defendant has a surgical clinic at Floor 1-2, Lot 12, Jalan Margosa Dua, Luyang Phase 8, 88100 Kota Kinabalu. The defendant was recommended to the plaintiff by Ringo Wong, an officer of the company the plaintiff worked for, as a result of which the plaintiff and the defendant met. The following is the plaintiff's account of what happened in the clinic of the defendant.

Plaintiff's Version

The plaintiff said the defendant on 9 July 1992, wanted to operate on him immediately there and then after she had checked his eyes but that he did not agree because of his work and because his relatives had not been informed. He also alleged that after the defendant had telephoned Ringo Wong, she told him that Ringo Wong would be paying the medical fees. He also alleged that he had told the defendant his previous treatment and operations by Dr. Molly. After telling the defendant that Dr. Molly had advised going to Kuala Lumpur for an operation, the defendant was alleged to have said the operation would be an easy one and that it is the same everywhere. He was then asked to return the next morning, that is on 10 July 1992, which he did and a computer test was done on his eyes. He was thereafter told by the defendant that the operation would be done on 11 July 1992. Though he signed two consent forms he said he was not told he may go blind as a result of the operation and instead the defendant had told him there was no danger to the operation and she had asked him not to be afraid. He also said the defendant had not told him that infection may set in after the operation. He also alleged the defendant had asked him whether he wanted an operation on both the eyes at the same time to which he had replied that one eye should be done first and the other to be done after its recovery. It was thus on 11 July 1992, that the plaintiff returned to the clinic and was operated on his right eye under local anaesthetic. He claimed that the defendant did not pre-or post-operatively administer any injection, pill or fluid to his eye. In the course of the operation he felt pain and that the defendant had told him not to be afraid and that she was getting the fluid out of the eye. After the operation, the defendant was alleged to have felt the lower lid of the operated eye with her ungloved hand. He does not know whether the defendant had first washed her hands before she felt the lower eye lid. He stayed overnight in the clinic and was the next morning, that is 12 July 1992, examined by the defendant on a couch. The defendant removed the bandage that was covering the right eye, then pressed the lower area of the right eye lid with her ungloved hand and applied some fluid to his eye. She then re-applied the same bandage. He also does not know whether the defendant had on this occasion washed her hands. He then went home after being told to change the eye-pad. He was given eye-pads and two types of medicine to apply to the eye but was not explained how they should be done. While at home, at every four hours interval he applied the medicine and changed the eye-pad in front of a mirror after he had washed and dried his hands with a clean towel. It was at about 12 p.m. on 12 July 1992, a Sunday, that he began to feel pain which grew in intensity in his right eye despite taking two tablets of Panadol. He tried to contact the defendant by telephone but no one answered the telephone. The pain persisted all through the night and became unbearable. It was only on the next morning, that was on 13 July 1992, that his brother drove him to the clinic arriving there before 7 a.m. and it was about 7.30 a.m. that they entered the clinic. He saw a nurse.

He heard the defendant arguing loudly with a nurse inside a room. This nurse later came out of the room and the plaintiff then asked whether the defendant was in to which the nurse replied the defendant had not arrived yet. He then told the nurse the unbearable pain he was undergoing whereupon he was given a Panadol. The defendant then emerged from the room and ushered him into her room where she removed the eye-pad and examined his eye. The defendant merely asked the plaintiff where the pus had come from and did not administer any medicine to the plaintiff. She then wrote a referral letter and asked the plaintiff to go to the Queen Elizabeth Hospital ("the hospital"), Kota Kinabalu. He left for the hospital while shivering with pain. He remained in the hospital for 20 days after being admitted on 13 July 1992. The right eye was lost due to Pseudomonos infection.

While in the hospital it was again Dr. Molly who treated him. According to Dr. Molly the plaintiff had to be admitted because both the pain and the severely infected eye could not be controlled. Immediately upon admission, Fortum, an antibiotic was given intravenously while Pethidine, a pain-killer, was given intramuscularly to the defendant without waiting for the result of a test to find out the bacteria that caused the infection for which a swab of the pus of the eye was taken. Dr. Molly diagnosed Panopthalmitis, an infection of the whole eye. Despite the said treatment and others that followed, the sight of the right eye could not be saved. The presence of Pseudomonos which caused the infection was detected. According to Dr. Molly, this type of infection is usually acquired from a hospital or from a clinic. As for her opinion that a Seton procedure ought to have been done and her opinion that the plaintiff ought to have been treated before the defendant sent the plaintiff to the hospital, I will return to them later after setting out the version of the defendant as to what happened in her clinic and after I have made my finding as to what really happened there. The following is the version of the defendant.

Defendant's Version

On 9 July 1992, the defendant saw the plaintiff who complained to her of blurred vision. She enquired and obtained a history from the plaintiff which she reduced into writing in a patient's card. The history revealed, among others, the operation done by Dr. Molly. She conducted an examination and found the plaintiff's both eyes to have a vision, aided by eye-glasses, of 6/36 minus and the intraocular pressure of the right and left eyes respectively to be 38 mm and 42 mm of mercury as against an accepted level of below 21 mm of mercury. She diagnosed the plaintiff to be suffering from chronic open angled Glaucoma. She prescribed medication, in the form of tablets and drops, to bring down the pressure and she recommended trabeculectomies of both the eyes which she knew had previously been done by Dr. Molly but that the fluid was not able to flow out. She did not think it was necessary to contact Dr. Molly as she was of the opinion that the history presented itself sufficiently as a result of her enquiry and examination of the plaintiff. She also concluded

that the plaintiff had no predisposition to infection. The plaintiff, as appointed, came back on 10 July 1992. The intraocular pressure was then measured at 20 mm of mercury despite medication which, according to the defendant, was unacceptable as she expected a pressure of 15 mm of mercury. The examination of the eyes revealed a constricted field of vision. The defendant thereafter again explained to the plaintiff the seriousness of his eye condition and the need for trabeculectomies on the eyes, to be performed on different occasions for each eye. She at first advised the left eye to be operated first because its intraocular pressure, it will be recalled, was 42 mm of mercury, was higher than that of the right eye which was at 38 mm of mercury. However, on 10 July 1992, the intraocular pressure of both eyes, despite maximum medication of 500 mg. of Diamox twice a day and 0.5% of Timoptol drops, only dropped to 20 mm of mercury which was considered to be at the higher border of normalcy and unsatisfactory. Dr. Molly had testified that continuous administration of the drug Mannitol, for bringing down the pressures, can only be given for a short time which means that medication cannot be used continuously to bring down the pressure. Similarly, the defendant was of the opinion that she should not continue with medication. It was thus that the defendant decided on operating the right eye first, as convention required though the left eye also needed an operation, which she scheduled to take place on 11 July 1992, for which the plaintiff signed a consent form.

As for the consent form, the defendant said she had explained to the plaintiff that the operation was a drainage operation for the eye that would create a pathway for fluid inside the eye to drain to the outside and that because there was a pathway from the inside to the outside there was also a pathway from the outside to the inside where germs can also enter the eye and cause an infection. The plaintiff, according to the defendant, appeared to understand the explanation. It was after the explanation that the plaintiff signed the consent form in her consultation in the presence of a nurse.

The Seton procedure was not considered by the defendant because that procedure, according to the defendant, carries with it a high risk of scarring the tissues and that was why she preferred a second trabeculectomy, the benefit of which operation outweighs the risk. She testified that there are 2 different ways of operating for trabeculectomies. One method engages a Fornix base flap while the second method engages Limba based flap. The flap is created so that when the fluid drains from the inside to the outside it drains underneath the flap which is then called a bleb. More of the evidence will be adverted to at a later stage in the course of my findings of facts regarding the conflicting versions of the events. First some observations on the demeanour of the witnesses.

Demeanour of Witnesses

As a witness the plaintiff was prone to exaggeration and was reluctant to reveal all, thus bearing testimony to his not being forthcoming with the truth where he thought the truth would not benefit his case. The plaintiff was also contradicted by other witnesses who testified for the plaintiff which made me conclude that at least his recollection of the events is not reliable. A few instances will demonstrate what I have said and will support my conclusion. When it was suggested to him that he had tunnel-vision, he appears not to agree but said that he could still see quite far and could see the side as well, said obviously to emphasise his contention that he could work as a quarry supervisor despite the glaucoma. But Dr. Molly testified that his sight was getting progressively worse, so much so that she had to perform surgeries on both his eyes in 1990. Ringo Wong testified that the plaintiff because of his bad eye sight could not work at night and that the plaintiff was stopped from driving the company's car as a result of an accident. The plaintiff attempted to show that his sight was alright before the operation by the defendant but the evidence points to a different direction. There is also that evidence of his that Dr. Molly did not tell him before she operated his eyes in 1970 that the operation may not be 100% successful whereas Dr. Molly testified, her testimony I cannot find any ground to reject, she did explain to the plaintiff. He maintained that no one explained the consent forms to him before he signed them but his brother Liew Sin Fook ("the brother") testified that the plaintiff told him that the documents he had signed were to give consent to the defendant to operate his eye which thus revealed the plaintiff's knowledge of the nature of the consent forms and which renders untrue the plaintiff's assertion that he was not explained the consent forms. There is also the allegation that the defendant wanted to operate on his eyes immediately but that he declined because he was still working. This was said, when read together with the assertion that the defendant rang up his employer to find out who was footing the bill for the operation, obviously for the purpose of painting the defendant to be a scalpel-happy mercenary though this issue was not pleaded. But this is a very wild allegation. If the defendant was really such a person, words would have got round long ago. Instead, and obviously because of her good reputation, the defendant was recommended to the plaintiff by the said Ringo Wong. Therefore, generally, the plaintiff's evidence is not only contradicted by other evidence of witness called by the plaintiff but, as a witness the plaintiff is capable of very wild allegations and his recollection of events unreliable. Mr. P.S. Ranjan, learned Counsel for the defendant, had submitted, and I agree with learned Counsel, that the plaintiff had made extravagant allegations in his statement of claim which the plaintiff did not bother to substantiate with evidence, allegations like faulty surgical technique and contaminated instruments. With those comments, I will proceed with my

findings on the other evidence where the parties are at variance. The first of the issues is whether medicine was given by the defendant to the plaintiff on 9 July 1992.

Contentions

Whether medicine given on 9 July 1992

Though denied by the plaintiff, I accept as the truth that the defendant on 9 July 1992, apart from giving oral medicine also gave the plaintiff eye-drops to be applied at home for the purpose of bringing down the intraocular pressures of both the eyes which were at 38 mm and 42 mm of mercury compared to the normal level of 21 mm. These details were recorded contemporaneously in the plaintiff's out-patient card maintained by the defendant. Apart from the outpatient record, the high pressures, diagnosed by the defendant, were corroborated by the fact that Dr. Molly had on 9 July 1992, in fact advised immediate treatment because, though she did not give the figures, she said the pressures did not stabilise despite treatment which can only mean that the pressures were high. If it was not for the medication given by the defendant how could the pressure had gone down to 20 mm of mercury on the next day. For that reason I am of the view that there is no truth in the allegation of the plaintiff that he was not given the eye drops other than the tablets. It is therefore not true that the defendant had operated on the plaintiff's eye without first stabilising the intraocular pressure. It was also recorded that a trabeculectomy was necessary and I accept that the defendant did tell the plaintiff that he may have to undergo that operation. This takes me to the next issue which is whether the defendant should have consulted Dr. Molly before deciding on the second trabeculectomy which Mr. Sugumar Balakrishnan, learned Counsel for the plaintiff, contended the defendant should have.

Whether necessary to consult Dr. Molly

The defendant testified that she did not find it necessary to consult Dr. Molly because she obtained a good history from the plaintiff and from an examination of his eyes. She was able to note, among others, that the eyes had peripheral iridectomy while her testimony adverted to knowing the plaintiff to have undergone previous trabeculectomies. Dr. Molly was of the view that the defendant should have consulted her about the operations she had performed in order to know what happened. Dr. Molly agreed that to a certain extent, a good account of the patient's past medical problem can be had by what the patient relates, by examination and by investigation and Dr. Molly agreed that the need to consult will only arise if the doctor thinks so. Dr. Lim Pitt Kent ("Dr. Lim") was also of the view that a good account of the history by the patient, by examination and by investigation can tell a lot about a patient's previous medical problem. He was also of the view that it is up to the doctor concerned to decide whether there is a need to refer to the previous doctor.

However, Dr. Paul Chew Tec Kuan ("Dr. Chew"), an ophthalmic surgeon called by the defendant, was more affirmative when he testified that it was not necessary for the defendant to consult Dr. Molly because the physical examination done by the defendant sufficed. In her notes and in the referral letter, the defendant had adverted to an "PI", "PI" being the abbreviation for peripheral iridectomy, being done by Dr. Molly. It was against this backdrop that Mr. Sugumar argued that, because the defendant had only adverted to peripheral iridectomy and not trabeculectomy, the defendant did not even know that Dr. Molly had performed trabeculectomies on the plaintiff. Learned counsel further argued that if the defendant had consulted Dr. Molly, she would have been told the reasons why a second trabeculectomy was not recommended and this would have been a major factor for the defendant to take into account. Dr. Molly had explained that a peripheral iridectomy is only a part of a full trabeculectomy. The defendant was cross-examined why, if she had known that trabeculectomies were done, she did not so state in her medical notes (D7) to which she explained, and I accept, that the findings of her examination are stated in the next page and the sketches and measurement are sufficient to indicate that trabeculectomies had been done. Therefore, since the defendant knew that trabeculectomies had been done before by Dr. Molly I would accept that there was no need for her to consult Dr. Molly, a view also shared by Dr. Chew, Dr. Molly and Dr. Lim, though the latter two in not so strong a term as that of Dr. Chew. Though not as positively as one would like, both Dr. Lim and Dr. Molly nevertheless said, in relation to whether the previous doctor ought to be consulted, that they would defer to the decision of the examining doctor, in this case, the defendant. For the reasons already stated, I am also of the view that on 9 July 1992, after the defendant had examined the plaintiff, she knew the plaintiff had trabeculectomies done before by Dr. Molly and it was therefore not necessary for her to consult Dr. Molly. There is, therefore, no basis for saying that the defendant's decision to do a trabeculectomy was not a sound clinical judgment because she did not know that the plaintiff had trabeculectomies done by Dr. Molly since the defendant was in fact aware of such operations. Apart from that the plaintiff had alleged that he was not explained the risk of operation by the defendant and it is to that issue that I will now turn to.

Whether risk of operation explained to plaintiff

The plaintiff said the defendant did not explain the risk of the operation to him whereas the defendant said otherwise. It is common ground that there is in law a duty on a doctor to warn the patient of any material risk in undergoing or foregoing surgery or treatment. This is how the law was stated in *Sidaway v. Bethlem Royal Hospital Governors & Ors.* [1985] 1 All ER 643 HJ, *viz.:*

> Held- (1) the test of liability in respect of doctor's duty to warn his patient of risks inherent in treatment recommended by him was the same as the test applicable in diagnosis and treatment, namely that the doctor was required to

act in accordance with a practice accepted at the time as proper by a responsible body of medical opinion. Accordingly, English law did not recognise the doctrine of informed consent. However, although a decision on what risks should be disclosed for the particular patient to be able to make a rational choice whether to undergo the particular treatment recommended by a doctor was primarily a matter of clinical judgment, the disclosure of a particular risk of serious adverse consequences might be so obviously necessary for the patient to make an informed choice that no reasonably prudent doctor would fail to disclose that risk.

(2) When advising a patient about a proposed or recommended treatment a doctor was under a duty to provide the patient with the information necessary to enable the patient to make a balanced judgment in deciding whether to submit to that treatment, and that included a requirement to warn the patient of any dangers which were special in kind or magnitude or special to the patient. That duty was, however, subject to the doctor's overriding duty to have regard to the best interests of the patient. Accordingly, it was for the doctor to decide what information should be given to the patient and the terms in which the information should be couched.

(3) Since the surgeon's non-disclosure of the risk of damage to the plaintiff's spinal cord accorded with a practice accepted as proper by a responsible body of neuro-surgical opinion and since the plaintiff had not proved on the evidence that the surgeon had been in breach of duty by failing to warn her of that risk the defendants were not liable to the plaintiff.

However, the Australian case of *Christopher Rogers v. Maree Lynette Whitaker* [1993] 1 CLJ 449 disagreed with ruling (3) of the decision, *supra*, when it approves of the following passage of *F. v. R.* [1983] 33 SASR 189, at p. 194, *viz.:*

The ultimate question, however, is not whether the defendant's conduct accords with the practices of his profession or some part of it, but whether it conforms to the standard of reasonable care demanded by the law. That is a question for the Court and the duty of deciding it cannot be delegated to any profession or group in the community.

and also when it approves the following passage of the Canadian case of *Reibl v. Hughes* [1980] 114 DLR (3d), at p. 13:

To allow medical expert evidence to determine what risks are material, and, hence, should be disclosed and, correlatively, what risks are not material is to hand over to the medical profession the entire question of the scope of the duty of disclosure, including the question whether there has been a breach of that duty. Expert medical evidence is, of course, relevant to findings as to the risks that reside in or a result of recommended surgery or other treatment. It will also have a bearing on their materiality but this is not a question that is to be concluded on the basis of the expert medical evidence alone. The issue under consideration is a different issue from that involved where the question is whether the doctor carried out his professional activities by applicable professional standards. What

is under consideration here is the patient's right to know what risks are involved in undergoing or foregoing certain surgery or other treatment.

The issue here is not what risks are material for disclosure and therefore it does not call for my decision as to whether to follow *Sidaway v. Bethlem Royal Hospital Governors & Ors*. or *Christopher Rogers v. Maree Lynette Whitaker* regarding deferring to medical expert evidence. In the present case, what is beyond doubt is that the plaintiff required urgent treatment, be it the Seton procedure or a second trabeculectomy, and it is thus imperative that the patient be convinced to undergo either of the treatment if his right eye was not to go blind. Given those circumstances it would not serve the interest of the plaintiff, especially when he had already shown reluctance to undergo the Seton procedure in Kuala Lumpur, to even hint that any surgery may make him blind which will certainly deter him from agreeing to any surgery and thus lose the only chance of preserving the deteriorating sight of his right eye. It would be sad if doctors just for the purpose of preventing themselves from being sued would thrust to a patient every possible risk, however remote and which may arguably includes death, associated with a surgery with the result that the patient would rather not undergo an operation. If a doctor felt that a patient needed an operation and that the benefit outweighs a remote risk and that in the doctor's opinion, based on his assessment of the patient' strait, the patient may be deterred if the remote risk is told to the patient, then the doctor should be allowed the therapeutic privilege of deciding whether or not to tell the patient the remote risk. No doctor should be liable on account of his decision not to tell the patient the remote risk which eventuated. But the issue in this case is whether the defendant had explained to the plaintiff the risk of infection and it is common ground that this must be explained to the plaintiff. Mr. Sugumar submitted that the defendant had only explained the "nature and procedure" of the operation and this, according to learned Counsel, can be discerned from the words used in the consent forms (P6) which reads:

Dr. Sharon Paulraj Eye Surgery Etc. ...

Consent Form

I Liew Sin Kiong ... hereby consent to undergo the operation/treatment of Right Trabeculectomy (drainage op to RE) the nature and purpose of which has been explained to me by Dr. Paulraj. I also consent to such further or alternative measures or treatment and to the administration of general & other anaesthetic for any of these purposes.

Date 11 July 1992 Signature ... (Signed by plaintiff)

I confirm that I have explained the nature and purpose of this operation/treatment to the person(s) who signed the above form of consent.

Date 11 January 1992 Signature ... (Signed by defendant)

The consent form, it must be borne in mind, is only a document to signify the plaintiff's consent to the operation. The document is not intended to spell out in detail whatever explanation which the defendant had given to the plaintiff regarding the operation's risk. Therefore, the fact that it is not stated in the consent form that the risk of infection was explained does not mean that it was not explained. The defendant had said she had explained the risk of infection and this she did by stating that the operation involves creating a pathway to allow fluid to drain from the inside to the outside of the eye which means that germs may invade the inside of the eye through this pathway and therefore there was a possibility of infection. Apart from adverting to the said consent form and the absence of any statement therein as regard the explanation of the risk of infection, Mr. Sugumar did not say why I should disbelief the defendant and instead acclaim the testimony of the plaintiff concerning whether the risk was explained. I cannot find any instance in the defendant's demeanour, save for one which I will advert to later but which in any event does not generally affect her credibility, where her evidence can be considered suspect. On the other hand I have already set out the many instances of the unsatisfactory nature of the evidence of the plaintiff. I am inclined to believe the defendant that she had explained the risk of infection to the plaintiff. Mr. Ranjan had further submitted, and I agree with the submission, that in any event the plaintiff cannot recover any damages because the plaintiff did not say that if he had been warned he would not have consented to the operation which proposition of law is supported by the case of *Bolam v. Friern Hospital Management Committee* [1957] 2 All ER 118 where it was held that in order to recover damages for failure to give warning the plaintiff must show not only that the failure was negligent but also that if he had been warned he would not have consented to the treatment. I will now turn to the events of the preoperative period. First to the issue of whether the defendant had acted properly when she on 11 July 1992, decided on a trabeculectomy of the right eye.

Whether the decision to operate was proper

Mr. Sugumar had adverted to the failure of the defendant to consult Dr. Molly as the basis for the conclusion that the defendant did not have sufficient material to make a clinical decision to operate and I have already, *supra*, decided that the material were available through a history given by the plaintiff to the defendant and through examination and investigation conducted by the defendant. Aside from that it was also submitted that Dr. Molly should have been consulted as to why she did not do a second trabeculectomy which may influence the defendant's decision whether to perform the trabeculectomy but the defendant had explained why she would not have agreed to a Seton procedure which Dr. Molly recommended and the defendant was not challenged as to her choice of operation. What the plaintiff must prove in this regard is that the defendant's choice, that is a second trabeculectomy, is not in accord

with what is regarded as proper by a body of skilled ophthalmologists. This is how it was put in *Bolam v. Friern Hospital Management Committee*, *supra*, at p. 121:

> But where you get a situation which involves the use of some special skill or competence, then the test whether there has been negligence or not is not the test of the man on the top of a Clapham omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have the special skill. A man need not possess the highest expert skill at the risk of being found negligent. It is well established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular act ... Counsel for the plaintiff put it this way, that in the case of a medical man negligence means failure to act in accordance with the standards of reasonably competent medical men at the time ... I referred ... to ... *Hunter v. Hanley* (1) ([1955] SLT 213, at p. 217) ... where the Lord President ... said this:
>
> > In the realm of diagnosis and treatment there is ample scope for genuine difference of opinion, and one man clearly is not negligent merely because his conclusion differs from that of other professional men, nor because he has displayed less skill or knowledge than others would have shown. The true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of if acting with ordinary care.
> >
> > A doctor is not guilty of negligence if he has acted in accordance with a practise accepted as proper by a responsible body of medical men skilled in that particular art ... Putting it the other way round, a doctor is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view. ...
> >
> > You must not look through 1957 spectacles as to what happened in 1954 ...

That statement of the law was applied in the Malaysian cases of *Chin Keow v. Government of Malaysia & Anor.* [1967] 1 WLR 813 and *Elizabeth Choo v. Government of Malaysia & Anor.* [1970] 2 MLJ 171. Mr. Sugumar did not point to any evidence which could support the contention that the defendant did not act in accordance with the standards of competent ophthalmologist. In fact, Dr. Molly, who was called by the plaintiff, testified that she herself had performed repeat trabeculectomy 5 to 6 times before in Sabah and they were successful though she was of the opinion that it may not be successful in the case of the plaintiff. However, Dr. Chew was positively of the view that the decision of the defendant to perform a repeat trabeculectomy was proper, which opinion I accept. Just because the defendant took a different view from that of Dr. Molly regarding a repeat trabeculectomy, it does not amount to want of care (*Bolam v. Friern Hospital Management Committee*; *Rich v. Pierpont, Elizabeth Choo v. Government of Malaysia & Anor.*, *supra*; *Maynard v. West Midland Regional Health Authority* [1984] 1 WLR 634;

Kow Nan Seng v. Nagamah & Ors. [1982] 1 MLJ 128). I move now to the events just before the operation where the plaintiff had pleaded that the defendant had failed to take due or adequate care to ensure an aseptic condition pre-, intra- and postoperatively.

Whether there was a failure to ensure an aseptic condition pre-, intra and post-operatively

As for these issues, this is how Mr. Sugumar submitted, *viz.*:

> 47. An eye is a vital organ. The plaintiff's eye had pre-existing damage (previous operation and glaucoma). Both PW3 and PW4 have indicated the desirability of prophylactic antibiotics either orally or intramuscularly both preliminary and post-operatively. Defendant claims she had given topical antibiotics. Submit inadequate in the circumstances.
>
> 48. Literature and evidence show that such administration of antibiotics reduces risk of infection. What risk would the defendant face if she had administered oral or intramuscular antibiotics pre- and post-operatively? None. Given the plaintiff's case history and past operation, the defendant failed in her duty in not doing so.
>
> 49. If the defendant had given oral or intramuscular antibiotics after the operation, the risk of a post-operative infection would have been reduced. Submit topical antibiotics like eye-drops inadequate to prevent a post-operative infection which in this case occurred very fast.
>
> 50. Defendant claims to have given pre-operative antibiotics but D10 is silent on this. D11 and D12 are very explicit as far as recording of medication given. Submit that D10 is silent because no pre-operative antibiotics given.

The defendant had testified that the plaintiff, prior to the operation, was sedated with two sleeping pills, injected with pain killer Tramal, given antibiotic drops every twenty minutes and rubbed with Chroramphnicol ointment on the eyelashes of both eyes to eliminate bacteria. During the operation, Gentamicin antibiotics were given by drops and these were, after the operation again given by sub-conjunctival injection. She did not give preoperative antibiotics orally or intramuscularly because that is, according to her, not the accepted standard route and the accepted standard route is topically which antibiotics would go to the target directly. She disagreed that the more effective way of preventing a sight threatening infection is by oral or intramuscular administering of the antibiotics. What do the medical experts have to say about this? Mr. Sugumar did not advert to any such evidence as supporting his contention and submission. Dr. Lim's testimony in this regard as follows:

> Depending on the clinical judgment of the doctor concerned, he/she may want to give prophylactic antibiotics just before and after surgery in order to reduce the risk of infection. This will depend on the type of surgery involved. Local antibiotics may be administered as in the case of the eye but injections may be

> necessary although it will depend on the nature of the surgery and the judgment of the doctor. The decision to give prophylactic antibiotics will also depend on whether a vital organ is involved and where there is a high infective risk due to pre-existing damage. The general health of the patient must also be taken into account particularly with diseases like diabetes.

It can be gathered from that testimony Dr. Lim was of the view that antibiotics can be given topically, which is the same as "locally", in eye surgery. He went on to say it depends on the judgment of the doctor concerned. Dr. Lim, though he mentioned injections, he never elaborated when and where it should be injected. So no support can be found in the evidence of Dr. Lim, who was called by the plaintiff, for the contention of Mr. Sugumar. I also cannot find anything in the evidence of Dr. Molly to say that she had given antibiotics intramuscularly in relation to the trabeculectomies she performed. As regards her practice in preparing a patient for an operation, this is what she said:

> First of all I made sure the eye is not red, and it is cleaned. Conjunctiva smear is taken for culture prior to surgery. I start them on antibiotic drops and one oral antibiotic prior to surgery.

Thus, she confirms it is proper to use topical antibiotics. She never say anything about intramuscular injection of the antibiotics though she said she gave antibiotics orally. Therefore, Dr. Molly is also of no assistance to the plaintiff's case. Apart from that, all the literature on this subject tends to point to the fact that the application of topical antibiotics by the defendant was a proper course to be adopted. Take for example *Survey of Ophthalmology*, Vol. 39, at p. 491, where it is said:

> Allen and Mangiaracine compared the incidence of post-cataract endophthalmitis with and without the use of prophylactic topical antibiotics. Of 600 operations performed without preoperative prophylaxis, the postoperative infection occurred in five (0.75%). Among 19,340 patients receiving various preoperative regimes, 17 postoperative infections occurred (0.08%), suggesting that the preoperative use of topical antibiotics reduces the incidence of postoperative endophthalmitis.

and also at p. 495 where it is said:

> The preponderance of evidence shows that the incidence of postoperative endophthalmitis is reduced when antibiotics are used preoperatively compared with the incidence of infection when they are not. Speaker and Menikoff's study suggests that the preoperative use of topical povidone-iodine also reduces the incidence of postoperative infection ...

Both passages speak of the use of topical antibiotics which reduced the risk of postoperative infection. It was topical antibiotics that the defendant had administered and this was described as proper by Dr. Chew. Therefore, the plaintiff had failed to establish that it is an established practice that preoperative antibiotics must be given orally and intramuscularly such that a deviation from such practice would amount to a breach of the duty of care. I am of the

view that the defendant had treaded on well trodden path and she cannot be said to be guilty of negligence (*Bolam v. Friern Hospital Management Committee*). Put in another way, the plaintiff had failed to prove that the defendant did what no skilled ophthalmologist would to (*Hunter v. Hanley* [1955] SC 20; *Elizabeth Choo v. Government of Malaysia & Anor., supra*). As for postoperative antibiotics, these were noted in the medical notes, D11 and D12, and the defendant was again supported by the nurse as to the administration of the medicine. I cannot find any evidence to even remotely suggest that the defendant in giving those postoperative antibiotics did something which no skilled ophthlmologist would do. That is not the end of this issue because Mr. Sugumar had submitted that the defendant is not to be believed wen she said she had given preoperative antibiotics because, according to Mr. Sugumar, to quote again:

> defendant claims to have given pre-operative antibiotics but D10 is silent on this. D11 and D12 are very explicit as far as recording of medication given. Submit that D10 is silent because no pre-operative antibiotics given.

D10-12 which are adverted to in the said submission of learned Counsel refers to the medical notes which the defendant kept. As for the page of the notes D10, it reads like this, *viz.*:

> 11 July 1992
> agreed for trab.
> 20|20
>
> **plan**
>
> 1. for R trab.
> 2. Diamox IV - 500 mgs
> 3.

The following two pages, D11 and D12, relate to the postoperative periods and they contain details of the medication, including details of the antibiotics, given to the defendant postoperatively whereas the preceding p. D10, *supra*, relating to the preoperative period, does not mention the administering of the antibiotics which the defendant said she had given preoperatively. The omission was explained by the defendant in the following words:

> D10, says intraocular pressure 20 for both eyes. "Plan" means proposal for right trabeculectomies and for 500 mgs. Diamox to be given intravenously to further reduce intraocular pressure prior to operation. I wrote "3" to complete my plan which was to give the patient pre-operative antibiotic, sleeping pills and an analgesic injection of Tramal. These substances are a routine in a trabeculectomy case.
>
> Q: Why did you not record these substances?
>
> A: I had intended to complete the plan of recording these substances but at the time I was perhaps interrupted by telephone calls, other patient or my staff.

If these substances had not been given, I would not have commenced operation.

As for her explanation, supra, as to the omission to record, Mr. Sugumar did not say why she should not be believed. There is nothing implausible in her explanation that the failure to record was due to an interruption in the process of the recording, which occurrence Dr. Chew said he had also experienced before. I therefore accept the defendant's explanation. That she had administered the antibiotics was also corroborated by the evidence of her nurse, Chio Kim Hong @ Shirla Chio ("the nurse"). I am not unaware that the plaintiff had testified that no drops were applied to the eyes before the operation but as between his evidence, I would prefer that of the defendant because, for the reasons I have already stated earlier on, I do not find the plaintiff to be a very truthful witness. Furthermore, given the routine precautions taken and described by the nurse regarding the preparation of a patient for operation, it is just not possible in this case for the defendant and the nurse to have both forgotten to apply the eye drops before and during the operation which is what the plaintiff wants the Court to believe. There is therefore also no substance in the allegation that the defendant did not apply antibiotics pre-and intraoperatively. The defendant had also said she gave topical antibiotics to the plaintiff during the operation which I accept as the truth. The defendant was cross-examined as to why she did not include these medical notes in the list of documents and why they were only disclosed at the commencement of the trial. Mr. Sugumar in this aspect had this to say in his closing speech, *viz.*:

Suspect Nature of D7-D15

The defendant herself claimed that D7-D15 were vital documents for defence and were at all material times in her possession. However, it was never disclosed in the List of Documents filed on 19 July 1995 and the defendant's affidavit verifying list of documents even goes to say that the defendant only had the documents referred thereto which did not include D7-D15. The defendant swore another affidavit on 20 December 1995 (the first day of the trial) to include D7-D15 in the list of documents. The plaintiff's solicitors were given copies of D7-D15 on 16 December 1995. No valid explanation given for the non-inclusion of D7-D15 in the July 1995 list of documents (See lines 30-37 at p. 18). Submit that not much weight should be placed on D7-D15 in the circumstances.

During the trial when the defendant was asked why she did not include the documents in the first verified list of documents, Mr. Ranjan had interceded to say that it was an omission on their part which upon realisation was quickly corrected. The defendant explained that the documents were, after she had learned about this suit, sent to her lawyers in Kota Kinabalu and Kuala Lumpur. She had therefore explained that the documents were sent to her lawyers but that her lawyers had failed to include them in the list. I accept that explantation as to the omission. Therefore nothing turns on the said omission. I turn now to the operation technique and the surgical instruments

used by the defendant in respect of which the plaintiff had alleged that Panophthalmitis was contracted as a result of faulty surgical technique and or through the use of contaminated instruments during the surgery.

Whether the surgical technique was faulty and whether contaminated surgical instruments were used

The plaintiff did not call any evidence to testify how the surgery should have been conducted as against what the defendant had done. As against this, the defendant gave details of the operation she carried out and it was not suggested to her at all that what she did was faulty. In any event, Mr. Sugumar did not advert to these allegations and I will take it that those allegations were abandoned. It is also the case with the allegation of contaminated surgical instruments which appears to have been abandoned. There is yet another allegation which is that the defendant took no steps to stabilise the intraocular pressure before surgery. The weight of the evidence is overwhelmingly against this allegation because the evidence show that the pressure of both eyes were on 11 July 1992, brought down to 20 mm of mercury prior to surgery compared to a high of 38/42 mm of mercury on 9 July 1992. Although it was suggested by Mr. Sugumar during cross-examination that the defendant had made entries in the medical notes just before the commencement of this trial, Mr. Sugumar did not follow through with this suggestion in his closing speech. Again I take it that he had abandoned the allegation that the defendant had doctored the documents. In any event, if really that was done and done for the purpose of this trial, than the details of the antibiotics that were given preoperatively, a matter that is hotly contested, would have been inserted to booster the defence case. Its absence does not support the allegation of the doctoring of the medical notes. The main thrust of the submission of Mr. Sugumar was actually directed at the postoperative events of 13 July 1992, which I will deal with shortly, but first the allegations concerning the examination, that is palpation, by the defendant of the operated eye without wearing sterilised gloves.

Whether palpation of the eyeball without wearing sterilised gloves was a negligent act

For a better appreciation of this issue, more of the facts of this case had to be stated. According to the defendant it was at 6 p.m., 11 July 1992, sometime after the operation, that she palpated the eyeball of the operated eye with her bare index fingers by using the no-touch technique for the purpose of ascertaining its condition. That was done by closing the eyelid and thereafter feeling the eyeball by touching the eyelid. In this way, the operated wound was not touched at all. For this purpose she washed her hands with antiseptic solution and rubbed them with alcohol solution. She maintained that the close eyelid formed an effective barrier against bacteria being transferred from her hands to the operated wound. That was the only occasion that she palpated the eyeball. She did not agree that the failure to use gloves was the source

of the infection. She also denied that it was a practice to wear gloves after washing the hands in antiseptic solution. Both Dr. Lim and Dr. Molly testified that they do not wear gloves when doing palpation. Dr. Chew said that the eyelid could probably form a barrier against bacteria contamination from the hand. Dr. Chew also testified that in the hospital where he worked no doctor insisted on wearing sterile gloves when palpating. He also said it is not essential to wear them if the hands had been washed. It was against the backdrop of facts that I have just related that the allegation that it was negligence on the part of the defendant not to have used sterilised gloves when she palpated the eyeball arose. Given the fact that all the expert medical evidence are pitched heavily on the defendant's side, I cannot see how the plaintiff can succeed in this allegation which I am of the view is not only not proven but the contrary practice appears to be the case, which is that it is not necessary to wear sterilised gloves for palpation if the hands had been washed in antiseptic solution. I turn now to the contention regarding whether there was another palpation which the defendant denied there was and no reason was advanced by Mr. Sugumar as to why I should disbelieve the defendant. With that, I come to the events leading to the discharge of the plaintiff from the defendant's clinic on 12 July 1992.

Whether there was pain after the operation and whether the defendant complained about it

In relation to this issue, Mr. Sugumar had submitted that:

> **defendant's Contention: Post-operatively the plaintiff was well and was discharged without complication and the plaintiff made no complaints and made no contact with the defendant until he saw the defendant on 13 July 1992.**
>
> Both the plaintiff and PW5 (the brother) testified that the plaintiff did have pain after the operation. The defendant and DW3, DW3, (the nurse), deny this. Submit that complaint of pain was indeed made and they were advised that it was normal after an operation.
>
> When the defendant examined the plaintiff after the operation there was inflammation of the eye-lid structure. In essence, this was an infection and the defendant admits so (Lines 34-62 at p. 85 and D12 "cells ++"). defendant also admits that such swelling would call for further examination and possible treatment. No evidence of the defendant having examined further or given any treatment for this swelling. Submit that this amounted to a breach of her duty of care post-operatively.

The relevant evidence are these. The plaintiff testified he felt and told the defendant about the pain during the operation and that at about 12 p.m. on 12 July 1992, when he was at home, he felt pain in the right eye, which grew in intensity and persisted despite taking two Panadol tablets. He tried contacting the defendant's clinic but no one answered the telephone. The pain became very intense that night and he was not able to sleep. On the next morning,

that is on 13 July 1992, the pain became unbearable and he was then taken by his brother to the defendant's clinic before 7 a.m. and there waited for the clinic to open. When cross-examined, he said that no eye drops nor ointment were applied to his eye nor any injection given to his arm before the operation. He further alleged that there was no conjunctiva injection nor oral medication just before the operation. Though he said he did not say anything while the operation was going on, he later on said he complained about the pain. As against this, the defendant and the nurse testified that the plaintiff, prior to the operation, was sedated with two sleeping pills, injected with the pain-killer Tramal, given antibiotic drops every twenty minutes and rubbed with Chroramphnicol ointment on the eyelashes of both eyes to eliminate bacteria. I have earlier, when dealing with the question of aseptic condition, gave my reason why I am of the view that the defendant did administer the medicine she described. I would add that the plaintiff was trying out to make out the defendant to be a butcher, cutting the eye of the plaintiff without first administering the pain-killer. If it was true that no pain-killer was administered to him before the operation, I would expect the plaintiff not only to complain that there was pain, he would have screamed, thrashed and kicked with his legs in pain. Since he did not do that, there is no truth in the plaintiff's allegation that he was operated on without first being administered pain-killer described by the defendant. Mr. Sugumar did not point to any evidence or demeanour or trait of the defendant for me to conclude that the defendant despite the complaint of pain by the plaintiff was capable of not topping up the pain killer which was a rather simple thing for the defendant to do and I cannot imagine the defendant not topping up the pain-killer when the plaintiff complained of pain. Therefore, if ever there was pain, the pain would only come after the pain killer had worn off after the operation. Even assuming that there was pain, was this then an indication that an infection had already set in? I am assuming that this is the point that Mr. Sugumar was advancing because from the wordings of the latter paragraph, *supra*, learned Counsel appears to say that the plaintiff should have been treated before being sent home on 12 July 1992, and that the defendant had admitted there was an infection. The defendant's evidence in this aspect calls for consideration. Mr. Sugumar had referred to the medical notes for support of his contention, the relevant part of which reads:

12 July 1992	- 1st Day Post-op Conj-injected Cornea - v.sli epithaedema Ac - mod deep Cells ++ flare ++ 10 pupil dilated

The defendant explained what she had written, *supra*, in this way:

> When I saw patient that evening, the conjunctiva was injected, meaning a bit red over the operation site which was not unusual. The rest of the examination involved looking at the cornea, the condition of the bleb, the depth of the anterior chamber, that is whether the anterior chamber was flat or formed. I also looked at the pupil site and I ascertained whether the eye was hard or soft.

The defendant said and Dr. Chew agreed, that as a result her examination of the eye, there was nothing that was cause for concern even though the operated site was red because that was not unusual. She was cross-examined on her notes, *viz.*:

> Q: Cellulitis?
>
> A: It means inflammation of the eye lid structure.
>
> It does not necessarily mean an infection. Cellulitis may be due to other reason too. Infection is part of an inflammatory response.
>
> Q: If there was a swell lid of the eyes or tissues surrounding the eye, would it call for further examination and possible treatment, generally?
>
> A: Yes.
>
> D12 notes of 12 July 1992 written prior to discharge. "Cells ++" means cells are present in the anterior chamber of the eye.
>
> Put: "Cell ++" denotes inflammation of the operated eye.
>
> A: I disagree.
>
> Q: "Flare ++"?
>
> A: It means, like the tyndall effect. If you shine a light in a smoky or dusty environment the particles in the air can be visualised. In ophthalmology when a beam of light is shown obliquely into the eye and particles are seen that is what we termed a flare.

It was upon those evidence that I have just reproduced that Mr. Sugumar submitted that the defendant had admitted that, in essence there was infection which cannot be true because she said inflammation does not necessarily mean infection. She is not contradicted by any other witness on this point. What then is "inflammation" and "infection" and what are the evidence in regard to this? Dr. Lim and Dr. Molly were not asked about this. Dr. Chew, who had the medical notes, confirmed that the examination done on 11 July 1992, after the operation had revealed no infection. He was not cross-examined on this point by Mr. Sugumar. I will accept the evidence of the defendant and Dr. Chew that there was no infection on 12 July 1992, when the defendant examined the plaintiff after the operation and thus, the medical notes referred to by Mr. Sugumar cannot mean that there was infection or that infection was

discerned or discernible. Therefore, what Mr. Sugumar had said is pure summation unsupported by any evidence. There is no evidence to support the contention that the plaintiff should have been treated further before he was discharged. Even if the plaintiff was suffering from pain before he was discharged from the clinic, I am of the view that the pain was the result of the operation rather than of any infection. Thus, it is true that when the plaintiff was discharged he was well and without complication though he may be suffering from some pain. This takes me to the next issue of what the plaintiff was advised to do when he got home.

Whether the plaintiff was told to change the eye-pad

The plaintiff had testified that the defendant had told him to change the eye-pad and was for that purpose given eye-pads to take home without telling him how to do it. Every four hours he changed the eye-pad. He said he would first wash his hands, then dry them with a clean towel and thereafter apply the new eye-pad in front of a mirror. When cross-examined he agreed that he was told to throw away the eye-pad when he reaches home but he insisted that the defendant gave him eye-pads to take home. The defendant in her evidence denied that she had given any eye-pads for the plaintiff to take home to apply to his eye. She explained the risk of infection from re-using any eye-pad and through the hands that were used to manipulate the eye-ball. That is why, according to the defendant, that she never re-use any eye-pad. She was cross-examined in the following manner, *viz.*:

> Q: Post-operative, there should be fresh eye-pads placed after eye-drops applied?
>
> A: The first post-operative day when he was sent home he had 1½ eyepad. On reaching home he was advised to discard. He was not to put any eye-pad. I did not give him sterile eye-pad to take home. The eye was to be unpadded till it heals.
>
> Process of healing starts from day of operation.
>
> Put: Since he is still in process of healing he was applying eye-drops and the eye had to be kept immobilised which can only be done by applying eyepad; eye-pad must be used.
>
> A: I disagree.
>
> Put: You did give him unused eye-pads to be used after the application of the eye-drops.
>
> A: I disagree.

The other doctor who gave evidence in this regard is Dr. Chew and his evidence is as follows:

Q: defendant had discharged the patient and he was wearing an eye-pad in your opinion if defendant had advised the plaintiff to remove the eye-pad upon reaching home, would that be appropriate?

A: Yes. That would have been appropriate.

Q: If defendant had given plaintiff eye-drops containing antibiotic to be applied after discharging would that be appropriate?

A: Yes.

Q: If the plaintiff had failed to remove the eye-pad as advised what is your opinion regarding such failure to follow advice?

A: Scientific studies had shown the padded eye grows bacteria faster than the non-padded eye as such if the eye had an infection it would progress faster it if had the pad.

Q: Should the eye-pad been removed at time of discharge from clinic?

A: There is a variety of practices here. Some Ophthalmologists would send the patient home with first a plastic eye shield but without any padding.

Other would send patient home with pad but with instruction to discard them at home.

Q: What is your practice?

A: I sent patient home without the pad.

It appears from Dr. Chew that it was proper for the defendant to have discharged the plaintiff with an eye-pad with instruction to remove them. Therefore, for someone like the defendant who had done 200 to 300 trabeculectomies before July 1992, and since there is no evidence that she had not during any of those occasions followed the accepted practice, I am inclined to believe that she did ask the plaintiff to remove the eye-pad when he went home and that she had not given any eye-pad to be used by the plaintiff at home. Using the eye-pad requires a lot of manipulation and the fact that no instruction was alleged to have been given by the defendant to the plaintiff regarding how to change the eye-pad supports the fact that the defendant did not supply any eye-pads for the plaintiff to take home to use. Apart from that, it is the plaintiff's words against that of the defendant and it becomes important for the Court to know why the one should be preferred to the other. I have, on the one hand, already adverted to the generally unsatisfactory manner in which the plaintiff gave evidence while on the other hand I cannot find anything in the evidence or in the manner the defendant gave evidence which is ground for criticism or reason for rejecting her evidence, except for one instance which does not disturb her credibility. The plaintiff had alluded to changing the eye-pad by himself at home in front of a mirror but he did not describe how he kept the eye-pad in place. He did not

mention any tapes being supplied by the defendant for the purpose. The brother also did not give evidence in support of his allegations. I therefore prefer the evidence of the defendant to that of the plaintiff. The history of this case continues with the plaintiff turning up at the office of the defendant on 13 July 1992, with his operated-eye already infected and displaying pus which the hospital analysed to be a Pseudomonos infection. It was against this background that Mr. Sugumar then argued, and which issue I will deal with next, that the doctrine of *res ipsa loquitur* applies.

Whether Doctrine of *res ipsa loquitur* applies

This issue was argued by Mr. Sugumar in the following terms:

> **defendant's Contention: The doctrine of *res ipsa loquitur* does not apply to this case**
>
> plaintiff underwent treatment/operation at QEH from 1989 to 9 July 1992 but did not have Pseudomonos infection (Lines 36-37 at p. 34). Between 9 July 1992 to 11 July 1992 the plaintiff did not have Pseudomonos infection (Lines 14-19 at p. 84). However, within 24 hours of his discharge from the defendant's clinic he has Pseudomonos infection. DW2 says that if Pseudomonos was acquired by the plaintiff at the time of discharge at midday on 12 July 1992 the infection could be seen on the morning of 13 July 1992 (Lines 10-13 at p. 109).
>
> PW3 and PW4 say that it is almost always acquired in a hospital/clinic setting.
>
> The question to be asked is why the plaintiff does not acquire Pseudomonos while being treated and operated upon from 1989 to 09 July 1992 at QEH suddenly acquires it after discharge on 12 July 1992.
>
> Nobody seems to know how he acquired Pseudomonos. It is impossible for the plaintiff to know what precise acts or omission led to him acquiring Pseudomonos in the circumstances. The defendant claims that she had employed asceptic technic or condition prior to and/or during the surgery until the conclusion thereof. She also claims palpation of the operated eye is an accepted practice and is therefore not a source of contamination since she had washed her hands with antiseptic prior to palpation. We are therefore in the dark.
>
> Submit that on the facts the doctrine of *res ipsa loquitur* applies: *M.A. Clyde v. Wong Ah Mei & Anor.* [1970] 2 MLJ 183; *National Chemsearch Corpn. (S.E.A.) Pte. Ltd., & Anor. v. Hotel Ambassador (Malaysia) Sdn. Bhd.* [1975] 2 MLJ 193 and *Wong Choon Mei & Anor. v. Dr. Kuldeep Singh & Anor.* [1985] 2 MLJ 373.
>
> Submit in the circumstances, the plaintiff is entitled to invoke this doctrine and the onus of proof is reversed. Further submit that the defendant has failed to rebut the inference of negligence.

I will return to Mr. Sugumar's submission, *supra*, after I have reproduced what was said about the doctrine of *res ipsa loquitur* by *Clerk & Lindsell on Torts*, 16 Edn., para. 10-135, *viz.*:

Doctrine of *res ipsa loquitur*. The onus of proof, which lies on a party alleging negligence, is, as pointed out, that he should establish his case by a preponderance of probabilities. This he will normally have to do by proving that the other party acted carelessly. Such evidence is not always forthcoming. It is possible, however, in certain cases for him to rely on the mere fact that something happened as affording *prima facie* evidence of want of due care on the other's part: "*res ipsa loquitur* is a principle which helps him to do so". In effect, therefore, reliance on it is a confession by the plaintiff that he has no affirmative evidence of negligence. The classic statement of the circumstances in which he is able to do so is by Erle CJ:

> There must be reasonable evidence of negligence. But where the thing is shown to be under the management of the defendant or his servants, and the accident is such as in the ordinary course of things does not happen if those who have the management use proper care, it affords reasonable evidence, in the absence of explanation by the defendants, that the accident arose from want of care.

It is no more than a rule of evidence and states no principle of law. "This convenient and succinct formula", said Morris LJ, "possesses no magic qualities: nor has it any added virtue, other than that of brevity, merely because it is expressed in Latin." It is only a convenient label to apply to a set of circumstances in which a plaintiff proves a case so as to call for a rebuttal from the defendant, without having to allege and prove any specific act or omission on the part of the defendant. He merely proves a result, not any particular act or omission producing the result. The Court hears only the plaintiff's side of the story, and if this makes it more probable than not that the occurrence was caused by the negligence of the defendant, the doctrine of *res ipsa loquitur* is said to apply, and the plaintiff will be entitled to succeed unless the defendant by evidence rebuts that probability. It is not necessary for *res ipsa loquitur* to be specifically pleaded.

This doctrine of *res ipsa loquitur* was discussed in some detail by the Federal Court in *M.A. Clyde v. Wong Ah Mei. & Anor., supra*, citing also the quoted passage which was from the case of *Scott v. London and St. Katherine Docks* [1865] 3 H., & C., 596, 601. The Federal Court further referred to the judgment of Morris LJ in *Roe v. Minister of Health* [1954] 2 QB 66,88, where he said: "there are certain things that do not normally occur in the absence of negligence and upon proof of these a Court will probably hold that there is a case to answer." A more elaborate statement by Megaw LJ on the working of *res ipsa loquitur* can be found in *Lloyde v. Midlands Gas Board* [1971] 2 All ER 1240, 1246, *viz.*:

> It means that a plaintiff *prima facie* establishes negligence where: (i) it is not possible for him to prove precisely what was the relevant act or omission which set in train the events leading to the accident; but (ii) on the evidence as it stands at the relevant time it is more likely than not that the effective cause of the accident was some act or omission of the defendant or of someone for whom the defendant is responsible, which act of omission constitute a failure to take proper care for the plaintiff's safety.

> I have used the words 'evidence as it stands at the relevant time'. I think this most conveniently be taken as being at the close of the plaintiffs case. On the assumption that a submission of no case is then made, would the evidence, as it then stands, enable the plaintiff to succeed because, although the precise cause of the accident cannot be established the proper inference on a balance of probability is that the cause, whatever it may have been, involved a failure by the defendant to take due care for the plaintiff's safety? If so, *res ipsa loquitur*. If not, the plaintiff fails. Of course, if the defendant does not make a submission of no case, the question still falls to be tested by the same criterion, but evidence for the defendant, given thereafter, may rebut the inference. The *res*, which previously spoke for itself, may be silenced, or its voice may, on the whole of the evidence, become too weak or muted.

This passage was cited with approval in another Federal Court case, *National Chemsearch Corpn. (SEA) Pte. Ltd., & Anor. v. Hotel Ambassador (Malaysia) Sdn. Bhd.* [1975] 2 MLJ 193, 197. Another Federal Court case that was cited by Mr. Sugumar is *Wong Choon Mei & Anor. v. Dr. Kuldeep Singh & Anor.* [1985] 2 MLJ 373 where the Court also considered doctrines of *res ipsa loquitur* the details of which we need not concern ourselves with since all the cases speak about the same doctrine in different words. Mr. Sugumar had in his submission, *supra*, said that the doctrine could be invoked because the plaintiff did not suffer from Pseudomonos when he had his operation in 1990 in the hospital but yet was infected after the operation on 12 July 1992, in the defendants's clinic. This, according to Mr. Sugumar, must have come about as a result of negligence. This begs the question of whether Pseudomonos can only set in when there is negligence and not otherwise, and this, in turn, depends on whether, if all the required, that is accepted as the norm, antiseptic measures had been taken, that would prevent Pseudomonos infection from happening. Dr. Lim testified that post-operative Pseudomonos infection is a serious nosocomial, that is hospital or clinic acquired, infection with a high morbidity. Dr. Lim also said that when a patient acquired nosocomial after undergoing an operation in a clinic and after going home, it is more likely that he got it in the clinic though the possibility that it was acquired outside the hospital cannot be excluded because that bacteria can be found as a commensal and can be found in sinks and around toilets. Of relevance is the passage in *Survey of Ophthalmology*, Vol. 39 which, in relation to a survey done concerning the use of topical antibiotics, gave a statistic of patients contracting postoperative infection, of 5 in 600 patients, where the operations were done without preoperative prophylaxis, and of 17 in 19,340 patients (0.08%) where they were done with various preoperative regimens. In my view, it must be against the evidence, opinion and survey that I have just set out that the issue of whether *res ipsa loquitur* can be invoked falls to be considered. Given the statistics I have just referred to, it means that proper preoperative antibiotic measures cannot totally eliminate postoperative infection. In this regard, what was said in *Girad v. Royal Columbian Hospital et al.* [1976] 66 DLR (3rd) 676, 691, can be applied to the circumstances of this case, *viz*:

> Although the treatment of the plaintiff was under the control of the defendant doctors it was not under their sole control in the sense that they could see, observe and react to the immediate effects of the external application of such treatment. It was hidden from their view and was subject to the unexplained mysteries of the plaintiff's own physiology.
>
> The human body is not a container filled with a material whose performance can be predictably charted and analysed. It cannot be equated with a box of chewing tobacco or a soft drink. Thus, while permissible inferences may be drawn as to the normal behavior of these types of commodities the same kind of reasoning does not necessarily apply to a human being. Because of this medical science has not reached the stage where the law ought to presume that a patient must come out of an operation as well or better than he went into it. From my interpretation of the medical evidence the kind of injury suffered by the plaintiff could have occurred without negligence on the part of the defendant doctors the maxim of *res ipsa loquitur* does not apply.

What was said there almost twenty years ago about medical science being, what I would term, an inexact science, still hold true. It is still "hit and miss" in a lot of areas in medicine. Since infection can still occur despite proper preoperative prophylaxis, it cannot be said in this case that the postoperative infection must have been due to of the negligence of the defendant because the infection could be one of those 0.08% cases of unexplained incidents of infection despite proper preoperative prophylaxis. Though the statistics show the risk of infection was small it is nevertheless an inherent possibility (*Considine et al. v. Camp Hill Hospital et al.* [1982] 133 DLR (3rd) 137) and accordingly I am of the view that the doctrine of *res ipsa loquitur* cannot apply to this case. Even if it applies, but because from the evidence that I have thus far referred to, the defendant had shown that she had applied the accepted preoperative prophylactic measures and had thus shown that the Pseudomonos infection may not have been acquired at the clinic but possibly at the home of the plaintiff though the defendant could not show how the infection occurred, I am of the view this rebutted the *prima facie* case of negligence (*Wong Choon Mei & Anor. v. Dr. Kuldeep Singh & Anor., Supra*, at p. 375). This journey through the events reaches those of 13 July 1992, when the plaintiff turned up at the clinic of the defendant with his operated eye showing pus. In fact, the bulk of Mr. Sugumar's arguments were directed at the events relating thereto. The pleading in this aspect of the claim is, I again reproduce, in the following terms:

> (d) failing to treat the plaintiff urgently on 13 July 1992 for panophthalmitis after this complication has settled in, in order to save the plaintiff's sight and for failing to provide adequate paid relief to alleviate the plaintiff's pain and suffering despite being qualified to do so and shunting him to the Queen Elizabeth Hospital, Kota Kinabalu when the plaintiff was willing for the defendant to treat him at the Sabah Medical Centre, Kota Kinabalu.

That will be the next issue that I am going to make my decision.

Whether the defendant was negligent in failing to treat the plaintiff urgently on 13 July 1992.

For the purpose of this issue, some of the facts have to be restated but with the necessary elaboration. As for the plaintiff this is what he said in examination-in-chief with regard to this issue, *viz*:

> At about 12 p.m. on 12 July 1992 I began to feel pain in my right eye. At first the pain was moderate but the paid began to grow intense. I do not really know from which part the paid came from. It was as if from the head . I took 2 Panadol but the pain persisted. I applied the medicine every four hours and I also changed the eye-pad every four hour after washing my hands. The pain did not lessen even after applying the medicine. I tried to contact the defendant but no one answered the phone. Then I found out from the appointment card that she worked only half-day on Sunday. By the night of 12 July 1992 the pain was very intense and I could not sleep till the morning. On the morning of 13 July 1992 the pain became unbearable. I went to her clinic before 7 a.m. and waited for the clinic to open. My younger brother took me there. I waited till 7.30 a.m. when I went up the clinic because I cannot stand the pain anymore. I opened the door and entered the clinic. I did not see anyone inside except for a nurse who busily moved around. I heard loud argument. I heard the voice of the doctor arguing with the nurse. The argument was in her room but the door to her room was opened. A nurse came out from the room a little while later. I asked the nurse whether the doctor had arrived at the clinic. The nurse replied she had not. I told the nurse that the pain was killing me. The nurse then gave me a tablet and a glass of water and told me that it was Panadol. I took the Panadol and waited for the doctor. The doctor then emerged from the room and asked me to enter. I entered and I talked to her. I told her of the killing pain. She then examined my eye after removing the eye-pad. She then said she can see pus and she asked from where the pus came from. I told her I do not know. She did not do anything. She just put back the same eye-pad. She did not give me any injection nor tablet nor any liquid medicine. She did not apply any medicine to the ye. I then asked her what is the position now and I told her the pain is unbearable. She did not do anything. After that she told me to go to the hospital. I then said to her that since she was the one who operated, the hospital may not accept me. She then said to me that she will prepare a letter to give to me. She wrote the letter, put it in an envelope and handed it to me. She asked me to take the letter to the hospital. I wanted her to treat me and give me medicine. I asked for the medicine. I went to see her so that she can treat me. I went straight to the hospital with the letter. My younger brother took me there. On the way to the hospital I vomited. When I left the clinic for the hospital I was shivering with pain. I do not know what time I arrived at the hospital. I stayed in the hospital for 21 days. I left the hospital on 1 August 1992.

The brother, now 29 years old, testified that he called the defendant's clinic but that no one answered. His other evidence are these:

On 12 July 1992 while I was at home plaintiff did ask me to telephone Dr. Sharon. I called but did not get through. No one answered the call. 13 July 1992 I took plaintiff to Dr. Sharon's clinic. He told me that his eye hurts. We reached Dr. Sharon's clinic at plus 7 a.m. We went into the clinic. When I entered the clinic I heard some argument as the door was opened. The argument took place in a room. There was a nurse outside. plaintiff asked the nurse who answered the doctor was not in. plaintiff told the nurse the pain. The nurse went into a room and get a tablet which plaintiff took. The doctor came out later. It was Dr. Sharon. The doctor asked the plaintiff to enter the room and gave the plaintiff a letter and she asked him to go to the hospital. Plaintiff was in doctor's room for about 10 minutes. After plaintiff got the letter we went to the hospital. While on the way plaintiff vomited.

The brother did not think about seeing another doctor or going to the hospital after failing to get through to the defendant's clinic. He disagreed that he could take the plaintiff to another doctor or to the hospital. He claimed he does not know that the hospitals were opened at all hours though he had been to a hospital in Kota Kinabalu before. As for the defence, the nurse said he saw the plaintiff sitting in the waiting room. She said it was probably after 8.30 a.m. because the clinic usually opens at 8.30 a.m. She denied telling the plaintiff that the doctor was not in. She was surprised to see the plaintiff still wearing an eye-pad. The plaintiff then told her that the eye hurts. She then questioned the plaintiff as to why he did not remove the eye-pad as advised by the defendant. The plaintiff did not reply. She then removed the eye-pad and saw a discharge from the eye and she took the eye-pad to show the defendant while at the same time telling the defendant that the plaintiff is complaining of pain. The defendant then asked the nurse to give two Paracetamol tablets to the plaintiff which she did. The plaintiff then went into the consultation room of the defendant where the defendant examined the plaintiff's eye with a slit-lamp and told the plaintiff that he has an infection which needed round the clock attention. According to the nurse, the defendant gave the plaintiff a choice of either the hospital or the Sabah Medical Centre and the plaintiff opted for the former. The defendant then contacted Dr. Kelwajit of the hospital and thereafter wrote a referral letter which the plaintiff took to the hospital. She, following the instruction of the defendant, applied a fresh sterile eye-pad on the plaintiff's eye before he left for the hospital. The nurse said she did not argue with the plaintiff. Save for the details, the defendant's account of these events are in tandem with that of the nurse. The defendant said she did not treat the plaintiff's infected eye, which she diagnosed as endophthalmitis, but instead send him to the hospital because:

(1) it was essential to take a swab of the pus of the eye and then, in order to minimise the risk of contamination, plate it directly on an agar plate for the purposes of a microbiological examination to determine the offending organism and any treatment before that step may mask the organism; and

(2) her clinic did not have the plate to plate the pus that contained the organism, which plating was to encourage the growth of the organism or organisms for the purpose of identification and the plates are only available at the hospital or the Sabah Medical Centre and which two centres are the only places in Sabah that have facilities for laboratory analysis of the specimen of pus;

She also said that a journey from her clinic to the hospital only takes between 20 to 30 minutes. She was cross-examined on her decision to send the plaintiff to the hospital and it was in the following manner:

Put: You could have on 13/7 done a swab of infection and had it sent to Queen Elizabeth Hospital or Sabah Medical Centre and immediately proceeded to treatment and still be in a position to establish the kind of organism.

A: I agree. The reason I preferred that the patient had swabs directly plated was to maximum the chances of growth of the bacteria on the plate. If the swab was already in transport media the organism may not have completely transferred to the plates and therefore any growth on the plate may not have been adequate.

Q: Despite plaintiff being in situation where imminent danger of losing sight that you still insist on 100% perfection in establishing the organism?

A: Because plaintiff was in imminent danger of losing his eye sight it was essential for the correct identification of the organism and appropriate treatment of the patient be instituted that a swab had to be done.

Dr. Chew was asked about the steps to be taken upon diagnosing an eye infection and this is what he said:

Q: 13/7 when defendant seen plaintiff regarding swabs, when an infection is diagnosed what is purpose of swab?

A: Swab is meant to culture an infective organism on the surface eye. In an eye which is an endophthalmitis which is an internal infection within the eye-ball a surface swab may not have great success in culturing the infective organism and it may be better to take a sample from within the eye-ball, aqueous or vitreous body under sterile condition as this is the best result for culture. This is called an aqueous or vitreous tap. A surface swab is called a conjunctiva swab.

Q: Which is more complicated procedure?

A: Aqueous or vitreous tap. More complicated more accurate more successful. Conjunctiva swab are simple but the risk of culturing the wrong organism from the eye-lid or eye lashes. Aqueous or Vitreous tap taken under local anaesthetic in a sterile condition. Aqueous or Vitreous tap should be done in an operating theater in a major hospital with available microbiological facilities.

Q: Is it benefit to have report from microbiological regarding the analysis of pus in this case?

A: Yes. It would be useful to know the sensitivity of the bacteria.

Q: Is there a practice to commence treatment of an infection after a swap had been taken?

A: This a standard teaching while treatment should not be delayed exceedingly long, it would be good if you could take a swab first.

Q: If treatment of the infection is commenced before a swab is taken what would be the consequences?

A: If treatment is the appropriate therapy and the bacteria is sensitive to the treatment the eye might improve. The opposite is also true, where the bacteria not being sensitive to the antibiotic then the eye might not improve and in this instance the swab might also be negative, bacteria growth being suppressed by the pre-swab antibiotic, so that when you need the culture result most it may not be successful in culturing the bacteria.

Q: Was defendant's decision to refer the case to the Queen Elizabeth Hospital for a swab to be taken there and for treatment to be commenced there in accordance with Opthalmologic practice?

A: Yes. It was.

Q: Defendant said she did not commence treatment because she wanted a swab to be taken at hospital first, do you support decision?

A: If swab could be taken within the hour, that would be a reasonable cause of action.

Q: When defendant gave referral's letter, was that appropriate?

A: Yes.

Q: If defendant had telephoned the hospital in advance regarding the case she was referring, was that appropriate?

A: Yes.

Q: What would be the condition of left eye of plaintiff?

A: Known to have severe Glaucoma of left eye. Would not have gotten better and if the pressure is poorly controlled that eye would have possibly worsened.

Dr. Chew also agreed with what is stated in *Principles and Practice of Ophthalmology,* Vol. 2, by Albert and Jakobiec, p. 1162, where it is said:

> Accurate diagnosis ultimately rests with the demonstration of infectious organisms within the eye by appropriate cultures and stains. Given the rapidity with which endophthalmitis can progress to irreversible visual loss, the prompt acquisition of specimens for culture in all suspected cases is an essential element of therapy.

and he also agreed with the following passage from *Surgery of the Eye*, edited by Waltman & Ors., p. 74:

> **Management of Postoperative Endophthalmitis**
>
> The problem often faced by the ophthalmologist in managing a case of postoperative inflammation is two fold:
>
> 1. Is the case one of infectious endophthalmtis?
> 2. Who should manage the case?
>
> The decision as to who will manage the case is critical. Fortunately, most ophthalmologists see only two or three cases in their careers, whereas some of the larger institutions or retinovitreal groups tend to see significant numbers on referral. Naturally, a certain degree of expertise and experience is developed that is beneficial to the overall management. Furthermore, the laboratory facilities, availability of infectious disease experts, and familiarity with often toxic drug therapies in their hands is a positive step toward better and safer therapy. Referral to a subspecialist or center competent to manage the case is often a wise decision, if geographically possible, and relieves the primary ophthalmologist of the pressure and responsibilities. If the primary ophthalmologist elects to treat the patient, he should be familiar with all the techniques and have available the facilities for investigation and treatment of the problem.
>
> Once a clinical diagnosis is made, therapy can be delayed only a very short time so as to allow for the proper specific cultures to be taken. By doing so, the responsible organism is easier to identify without the influence of prior antibiotic therapy. If the delay is expected to be more than an hour or if the referral specialist or center are at some distance away, then therapy should be begun immediately with topical mydriatics, steroids and antibiotics, and even systemic agents. In cases where I have begun treatment several hours before getting vitreous culture, I have still generally been able to identify the responsible organism.
>
> In general, any patient with endophthalmitis, suspected or proven, should be admitted to hospital for investigation and treatment. Management as an outpatient cannot be intensive enough for obvious logistic reasons.

Briefly stated, Dr. Chew and the literature, *supra*, approve of the action of the defendant in sending the plaintiff to the hospital without first treating the infection. The literature cautions that the treatment should not be deferred if the delay is expected to be more than an hour or if the referral specialist or center are at some distance away. In our case, the distance between the clinic and the hospital was a mere 20 to 30 minutes' car ride distance away and the plaintiff could be treated within an hour of leaving the clinic. The defendant

did not have the facility for round the clock care nor the agar plate for culturing a specimen for microbiological examination. Dr. Molly gave conflicting statement as to what should have been done when an eye infection was diagnosed. When examined-in-chief, she said she had ordered a swab to be taken and she, in cross-examination, stated that to be the correct procedure. But she later appears to change her mind when she did not agree that it is important to take a swab once an infection is diagnosed and instead said she would start treatment immediately. She is not supported by the literature. Anyway when re-examined her evidence is as follows:

> Q: Can there be any justification for the defendant to find or refuse to give anti-biotic and pain killer before transfer to Queen Elizabeth Hospital when she had already observed severe infection on the operated eye?
>
> A: In my book a fellow colleague has his or her own justification for what he/she did. If I was in that position I would give the antibiotic and the pain killer.

It appears from that piece of evidence that Dr. Molly was not prepared to say what the defendant did cannot be justified. In fact, she appears to say that it was up to the judgment of the defendant. As for Dr. Lim, his written opinion on the subject is as follows:

> In any post-operative infection, it is essential to start antibiotics as soon as possible after taking specimens for microbiological examination and before waiting for the results. Local toilet of the wound may be necessary especially when there is abscess formation or discharge. Adequate pain relief is also part and parcel of good management. If possible, an appropriate antibiotic injection must be given before transfer as there is bound to be a delay of hours before treatment is instituted at the receiving hospital. In the case of the eye, this delay could result in the loss of sight in a matter of hours.

In his testimony he was of the view that an abscess-discharging eye infection should be treated immediately if the facilities are available before the patient is transferred from a private clinic to a hospital. This, according to Dr. Lim, involves a clinical judgment. He also said that only Sabah Medical Centre and the hospital have the facilities for microbiological examination. He was also of the view that a specimen of the pus must first be obtained before treatment because the treatment interferes with the analysis of the specimen. In re-examination he was asked and he answered:

> Q: If your patient just come back and complaints of severe excruciating pain and you observe infection, i.e., abscess of the eye, would it be reasonable on your part to shunt him to somewhere when you could give him treatment there and then bearing in mind you said in the case of eye infection, patient may lose vision in a matter of hours if there is a delay in commencing treatment?

A: The judgment of the doctor then is of paramount importance. This judgment will be influenced by (1) what can be done at that time and whether you have the facilities or the nursing staff to look after the patient. If you do not have, then you will be justified to refer because after doing any procedure the case is very important but it you do decide to refer, you will still do what you can, what we call by initiating treatment and giving pain relief which is very important. I think a lot of factors are involved but I would respect the decision of the clinical judgment of the physician or doctor at that time. Giving an anti-biotic injection does not require nursing care and standby staff.

From that piece of evidence, it seems to me Dr. Lim was not prepared to condemn as wrong the conduct of the defendant in not treating the plaintiff before sending him to the hospital. Though in his opinion, it takes hours before a person can be attended to in the hospital but this is not borne out by any evidence. Dr. Molly testified that she attended to the plaintiff at sometime after 10 a.m. and the evidence shows that the plaintiff left the clinic at around 9 a.m. or thereabout which means the plaintiff was in fact treated within an hour of leaving the clinic. In any event, given the short distance between the clinic and the hospital it was not unreasonable for her to expect treatment by the hospital within the hour. In the end, the plaintiff could not rely on the evidence of Dr. Molly, because she was ambiguous, not that of Dr. Lim, because he deferred to the clinical judgment of the defendant, to establish the case that the defendant was negligent in not treating the plaintiff before sending him to the hospital. All the doctors called to testify emphasised the importance of taking a specimen of the pus of the infected eye for the purpose of culturing and identifying the organism that caused the infection which objective may not be attained if antibiotic treatment was given before identifying the organism. Since the defendant had done what the general body of practitioners, including those practitioners called by the plaintiff, would do, and since the defendant in her clinical judgment was of the plaintiff, would do, and since the defendant in her clinical judgment was of the view that she could not manage the eye infection, I find that the defendant is not negligent in sending the plaintiff to the hospital before treating the eye infection. In fact, there is no expert medical opinion (except for Dr. Molly's ambiguous stand) to say what she did was not in accordance with accepted practice which makes her case stronger for finding not negligent because even if there is a different school of thought as to what should have been done the law allows such differences of opinion regarding the treatment to be given (*Bolam v. Friern Hospital Management committee, supra,*) and thus allows her to deal with the plaintiff in a way different from what Dr. Molly said should be done without being condemned as being negligent. Mr. Sugumar had submitted that the defendant had said the taking of a swab and the waiting for its results was uppermost in the defendant's mind. I do not agree. The defendant did not say that waiting for the result was uppermost in her mind. Taking a specimen and obtaining the result of the microbiological examination of the specimen are two separate

things. The importance of taking the specimen before treatment had already been explained and this was what the defendant adverted to and not the result of the microbiological examination. It is not the defendant's case that antibiotic treatment cannot be given after the specimen had been taken, which misapprehension Mr. Sugumar appears to labour under. Mr. Sugumar had posed the question of why, if the taking of a swab was really uppermost in the defendant's mind, the defendant did not in her referral letter expressly request the hospital to take a swab before administering intravenous antibiotics. The defendant had answered the question in the following terms:

> Not in letter because medical officer whom I had telephoned and written the letter to and who had trained under me did not have to be told the essential step of swabbing an eye first before the administering of the antibiotic.

which answer I accept as plausible and the events that follow justify her faith in the doctors in the hospital knowing what to do after they received the plaintiff with the referral letter. It was next contended by the learned Counsel that if the defendant had any valid reason for referring the plaintiff to the hospital the reasons would have been recorded in the medical notes but since there was none that, according to learned Counsel, justify the conclusion that there was no valid reasons for her decision. The medical notes (D13) after adverting to, among others, the finding of pus contains a note "Plan Admit to hosp." She was not cross-examined on why she did not state in the medical notes the reasons for transferring the plaintiff to the hospital and also Mr. Sugumar did not say why the reasons should be stated in the medical notes. In any event the medical notes adverted to the discovery of pus and thereafter to the admission to the hospital while the referral letter speaks of early endophthalmitis, an infection of the eye. When one reads all these together one can conclude that the reason for referring to the hospital was the discovery of the pus in the infected eye and her conclusion that it was endopthalmitis in its early stage which the defendant cannot manage I, therefore cannot see any justification in concluding that the absence of any note stating explicitly the reason for admitting the plaintiff to the hospital means the reasons for referring the plaintiff to the hospital now proffered by the defendant are an afterthought. There were many other submissions directed at the defendant's decision to refer the plaintiff to the hospital without first treating him which are effectively answered in the course of and as a result of my findings of facts even though I did not make pointed reference to them; I, therefore do not propose to go through them. There is just one more issue concerning the issue of negligence that had to be considered.

Whether the defendant was negligent in not giving the plaintiff the appropriate pain killer

When the plaintiff presented himself to the defendant on 13 July 1992, pus was already discharging from the operated eye which the defendant diagnosed as early endophthalmitis. On top of that the plaintiff complained of pain to the nurse who in turn relayed the information the defendant resulting in the prescription of two tablets of Paracetamol which apparently did not work because the plaintiff vomitted in the car while on the way to the hospital due, probably, to the paid. Dr. Molly testified that the plaintiff cried and complained to her of severe pain when she saw him in the hospital on 13 July 1992. She was also of the view that an abscess-discharging eye would be accompanied by severe or excruciating pain and she accordingly gave the plaintiff intramuscularly a strong pain killer called Pethidine. Dr. Lim testified that it was not sufficient to give Paracetamol where there was severe pain and infection but he qualified that by also saying that the choice of anagelsic depends on the attending doctor's assessment of the severity of the pain. He also said the pain could be treated before referring the person to a hospital. As against these evidence, the defendant testified that since the plaintiff did not indicate to her what kind of pain he was suffering from she could not accept that Tramal or Pethidine, both strong pain killer, ought to have been administered. She was questioned by Mr. Sugumar and the following are the question and answers regarding this aspect of the case:

Q: On being told by your nurse that he had pain, you made a clinical judgment to administer paracetamol but you did administer medicine when you saw pus on 13/7, could you explain?

A: I did not myself remove the pad from the patient's eye. When patient arrived at the clinic there were other patients and there was at least one in my consultation room. When my nurse went out, I do not know why, he saw the patient sitting in the waiting room. The patient had eye-pad applied to his right eye which she took off and enquired about what the patient had told her that he had pain. When she took off the pad she brought it into the consultation room to show me and she told me the patient had pain. She did not tell me the severity of the pain . She said just pain and since I had a patient present with me at that time and I did not know how long I would take seeing that person which is why I asked my nurse to give him 2 tablets of paracetamol so that it could relieve his pain until I have finished seeing the patient inside the room. When he came into my consultation room, I examined him first because I knew that my nurse had given him pain killers before. When he was before me he did not complain to me that he was in pain. I did not give treatment for the pus I saw because I wanted a swab taken.

Q: When told of pain through nurse and observed pus, did you make clinical judgment pain related to infection?

A: Pain could have been related to infection and to other causes too.

Q: A postoperative infection is a serious matter?

A: Yes.

Q: Would pus in the eye entails severe pain?

A: If would entail pain but I would not know the severity.

Q: Isn't it your duty to enquire from plaintiff who was examined by you as to why he was having the pain and how he acquired the pain?

A: Yes, it is my duty.

Q: Did you enquire?

A: I cannot recall.

Put: You did not enquire.

A: I disagree.

Put: On 13 July 1992 you did not exercise reasonable care skill and diligence to be expected of an experienced trained and skilled eye specialist when you failed to administer immediate treatment to plaintiff before transfer.

A: I disagree.

Paracetamol is prescribed when a patient complains of pain, any pain.

She maintained that Paracetamol was adequate for postoperative infective pain. Dr. Chew in this regard testified that pain is a major feature of an eye infection and that pain always occur in acute infection but may not occur in chronic infection. Unfortunately he was not asked what he meant by the words "acute" and "chronic". Could "acute infection", which is always accompanied by pain be taken to mean Panopphtalmits and "chronic infection", where pain is not necessarily present, to mean Endopthalmitis? The answers were not provided by any of the medical expert witnesses. Dr. Chew also said that pain is subjectively perceived. When cross-examined whether Paracetamol was adequate when it was administered to the plaintiff on 13 July 1992, he replied that pain is subjective and he would not be able to comment but he agreed that the plaintiff would at that time be undergoing severe pain. Dr. Chew's last words on this subject were in answer to the following question, *viz:*

Q: If patient after Paracetamol from nurse sees the doctor in the consultation room and the doctor in her judgment thinks the pain is adequately treated with Paracetamol already given, would you give weight to that judgment?

A: Yes. I will give weight to that.

Thus opinions of the medical experts appear to be divided. Dr. Molly was affirmative that Paracetamol was inadequate and that way she gave Pethidine. Dr. Lim was also of the opinion that Paracetamol was inadequate for severe pain but he qualified his statement by further saying that the choice of analgesic depended on the assessment of the severity of the pain by the attending doctor. Dr. Chew, on the other hand, was non-committal though he said he will give weight to the judgment of the doctor who prescribed Paracetamol. As against that, the defendant's stance was, what I can call, extreme because she said Paracetamol was suitable for any pain. It is to that statement of the defendant that I will first turn to. The defendant's evidence that I have hitherto referred was unblemished and I have said so. But in regard to the issue of whether Paracetamol was adequate, she was stretching it too far when she claimed that Paracetamol was adequate for all pain. If what she claims is right, why is there a need for stronger pain killer like Tramal and Pethidine. She is also not supported by her own witness, Dr. Chew, who testified that Paracetamol would not be adequate in the case of severe pain which severe pain would accompany any infected discharging eye which the plaintiff had. It still remains to be answered whether it is a good clinical judgment for her to maintain that since the plaintiff did not indicate to her what kind of pain he was suffering from she could not accept that Tramal or Pethidine ought to have been administered. The defendant had said that when he examined the plaintiff, which was after the nurse had given two tablets of Paracetamol to the plaintiff, the plaintiff did not complain to her of any pain and that was why she did not give any further pain killer to the plaintiff. It was therefore her clinical judgment or assessment that the plaintiff did not require any further pain killer. But Dr. Molly said the plaintiff needed and was injected with Pethidine. However, since the undisputed medical evidence is that pain may get progressively intense from hour to hour, it may well be that by the time Dr. Molly attended the plaintiff, the pain had gone intense while it was not so bad in the clinic of the defendant. The brother had said the plaintiff left the clinic for the hospital at around 8 a.m. but since the clinic opens only at around 8.30 a.m. it is nearer the truth that the plaintiff may have left the clinic at around 9 a.m. Dr. Molly testified that she attended to the plaintiff not more than an hour before 11 a.m. which puts it at around 10 a.m. and that would be approximately about an hour since the defendant had examined the plaintiff. The severity of the pain that presents itself to the defendant could have been, because of the time difference, much less than that presented to Dr. Molly later on. Despite her unacceptable statement that Paracetamol is good for any pain irrespective of its severity, I am still prepared to accept that she should not be faulted for not administering any further pain killer after the two tablets of Paracetamol because in her judgment it was not necessary. This is because the expression of pain on the part of the plaintiff, verbally or through contortions of the face, may not have manifested itself in her consultation room, and it may be because the plaintiff had a higher level of tolerance for pain. By the plaintiff's own account he could tolerate pain since he experienced

pain from 12 July 1992, and did not seek alternative doctor to treat him when he could not contact the defendant. Therefore, it is just probable that the plaintiff may not have complained of any more pain to the defendant, as the defendant alleged, when he was examined by the defendant in the consultation room after being administered two tablets of Paracetamol. Dr. Lim, a witness, it will be recalled, called by the plaintiff, testified that it was up to the assessment of the attending doctor as to what anagelsic to give. As regards pain, I am of the view that a doctor is only required to prescribe pain killer when a patient complains of pain and there is no duty on the part of a doctor to enquire whether a patient is in pain when the patient does not complain of any pain. In this case, if the two tablets of Paracetamol were not adequate when the plaintiff was before the defendant in the consultation room, then it is for the plaintiff to tell the defendant and there is no duty on the part of the defendant to enquire any further as to whether the two tablets of Paracetamol were sufficient. Therefore, a failure to enquire in the circumstances of this case cannot amount to negligence. Giving the circumstances I have stated, I am of the view that she is also not negligent in not giving any further pain killer before referring the plaintiff to the hospital.

Conclusions

In the premises the plaintiff's claim is dismissed with costs to the defendant**.** If it is of any comfort at all to the plaintiff, he can rest assure that Mr. Sugumar was tenacious in pursing his claim. Learned Counsel was so full of tenacity that I have, at one stage of the proceedings (though not recorded but it should be vivid to everyone's recollection since it happened only a short while ago, that is on 28 December 1995, when Dr. Chew was cross-examined), to restrain him from any further outburst which I termed an abuse of the witness when he was not getting anywhere with Dr. Chew. Given the reluctance of doctors to condemn a colleague, Mr. Sugumar did the best that can be expected of good Counsel and even in one instant, as I have just said, overdoing it by putting to Dr. Chew that he was "no doctor". I believe that was said out of frustration rather than a malicious intent but nevertheless was annoying or insulting to Dr. Chew which I immediately reminded Mr. Sugumar of the prohibition of the Evidence Act 1950, and which I now discern to be s. 152 of the Evidence Act 1950. As for this case, the facts do not support the plaintiffs claim. There is no lack of sympathy from all the parties concerned but, as had often been said before, though I am also sympathetic to the plaintiff's plight, my decision cannot be swayed by my sympathy but must be guided by the law and the facts of this case. The facts and laws pertaining to this case are such that the defendant was not negligent at all. There is still one more task for me which is to find what the damages should be if the defendant had been guilty of negligence.

Amount of Damages

In case I am wrong in my decision on the issue of liability, the damages I would award would have been as follows. The plaintiffs eye sight was very constricted just before he was treated by the defendant. The cases of *Poh Sum Hong v. Lim Peng Chia* [1979] 1 MLJ xxxviii and *Rahim Bin Sian v. Mesdi Bin Warian* [1985] 1 MLJ 442 were both dealing with hitherto good eye sight and thus may not be a good yard stick to apply to the present case since the plaintiff has a deteriorating eye sight which required urgent operation. But then again, as one must take the plaintiff as one finds him, it must be taken into account that though one eye was involved, the plaintiff may nevertheless go totally blind since the sight of the other eye that was not operated on was deteriorating and the plaintiff cannot depend on it for his sight if the sight of the other eye should be lost. That means, the operated eye is more valuable to the plaintiff than that of another person who could fall back on another eye. As it turned out, the plaintiff is now almost totally blind since the other eye is virtually of no use to him. Therefore, I would have awarded for pain and suffering and loss of amenities a sum of RM40,000 and agreed special damages of RM284 with interest at 6% per anum from the date of the service of the writ to the date of judgment and thereafter statutory interest at 8% per anum. As for loss of future earnings, there is no evidence that the plaintiff would definitely go blind without the operation but the left eye of the plaintiff which was not operated by the defendant had gone almost blind. That Dr. Molly should recommend further surgery for both eyes is testimony to the deteriorating condition of both his eyes. Since the left eye was good for about four years from 1992 to 1996, I am of the view that the same is also true of the right eye if it was not operated on. Therefore the plaintiff's loss of future earnings is confined to four years at RM1,000 per month, which was his last drawn salary before the eye operation by the defendant. Therefore, the award for loss of future earning is RM48,000 (48 months x RM1,000). The plaintiff had hitherto been taken care of from money provided by the family members who did not claim against the defendant and since there is no question of future care for which the defendant is to be accountable for because the plaintiff would have gone blind in any event and had gone blind by the time of the trial, there will be no award for this head. As for aggravated or punitive damages, the evidence does not even remotely support the submission of Mr. Sugumar that the defendant was "ruthless, cold-blooded and heartless" and her decision to send the plaintiff to the hospital can in no stretch of imagination be regarded as one. I cannot find any evidence to support the awarding of punitive or aggravated damages. Even if the defendant had not visited the plaintiff in the hospital, which I find otherwise, and notwithstanding that the defendant had sent the plaintiff a bill for the operation, which I see nothing wrong with since the defendant maintained that she was not negligent, those facts cannot justify punishment with substantial damages against her. Since the

total sum I would have awarded would not justify the claim being filed in the High Court, the costs to the plaintiff would be in accordance with the scale of the Subordinate Courts.

Reported by Gan Peng Chiang